

DOCUMENTS SECTION

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THE SURGEON'S

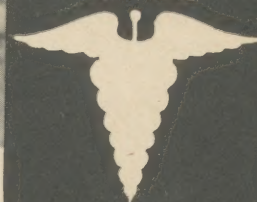
Circular Letter

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A FAR EAST
PERIODICAL



OF ARMY
MEDICAL SERVICES
INFORMATION

MEDICAL SECTION • GHQ • FEC, SCAP AND UN

APD 500

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Lt. Dean, Osaka Army Hospital nurse, instructs personnel of Norwegian hospital.



Maj. Gen. Hume chats with Lt. Gen. Sir Kingsley Norris, Australian Surg. Gen.



First Canadian nurses in FEC are welcomed by a member of Australian Nursing Service.



Infantry officer, wounded in rt. thigh, takes urink before trip to aid station.



Soldier of 187th Airborne RCT feeds starving Korean baby at command post.



Member of 32nd RCT (rt), struck in leg by sniper's bullet, is helped to aid station.



Non-battle casualty. A 65th RCT soldier suffers an acute attack of appendicitis.



Crude litters constructed of sticks and wire, used by Communist forces.



Wounded chinese overwhelm medical facilities, regimental aid station, 24th Div.

On the cover

A wounded soldier is removed from rugged mountainous area near Chorwon, Korea.

Litter-bearers and their armed escorts are members of the 8th Cavalry Regiment.

All photographs are from U. S. Army Signal Corps unless otherwise stated.

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ADMINISTRATIVE

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ARMY MEDICAL SERVICE OBSERVES 176TH ANNIVERSARY

Most medical units throughout the world, particularly those in Korea, were far too occupied to celebrate the 176th anniversary of the Army Medical Service. The 27th of July was merely another day of "business as usual."

Some found time to look back with pride upon the 176 years of continuous service to the military and to humanity. But the memories of past deeds are somewhat diminished by the accomplishments that have taken place during the Korean war. In the face of almost impossible obstacles, the Army Medical Service has steadily reduced the disease rates and increased the odds for survival. The rate of recovery for battle casualties is represented by a figure never believed attainable.

There is still a tremendous task before the members of the Service. When times of peace come, the workload may be made lighter but no one yet has invented a peace that will overnight put an end to suffering of war. It will remain the responsibility of the Medical Service to continue without interruption its treatment of the sick and wounded.

General Ridgway paid his respects to the Medical Services in a statement released on the anniversary date.

"When the Army Medical Service attains its 176th birthday on 27 July, its members can look back on an uninterrupted period of efficient service to the na-

tion and to humanity in every war we have fought. It has been my privilege to know this effectiveness at firsthand in three wars.

"Never has a more brilliant page in the long history of the Army Medical Service been written than is now being written in Korea and Japan. Alone of all America's wars, the Korean conflict has been without an epidemic on our side, though the enemy has not been so fortunate. Application of modern medical methods and sound administration have resulted in the lowest death rate yet known in war, less than half that of World War II which was by far the lowest up to that time. Devotion to duty of our medical personnel of all ranks in the area of combat, heroism in the presence of the enemy, prompt and skillful removal of the wounded to advanced hospitals have played an important part in attaining these satisfactory results.

"I salute the hard working, efficient, courageous, and selfless personnel of the Army Medical Service and wish for that Service continued success in the future."

Major General Armstrong, Army Surgeon General, observed the day as a high point of his tour of medical units in Korea. The General said:

"On the Army Medical Service's 176th birthday, 27 July, I should like to extend my greetings to all individuals assigned to or in support of the Army Medical Service in the Far East Command. The pages

of the history of our organization have never been more filled with heroic deeds, sacrifices and accomplishments than those of the past year. I particularly salute our colleagues of all United Nations forces who have been or now are in Korea. By your tireless devotion to our mission at cost of self-sacrifice and hardship, you stand as an inspiration to us all and exemplify the highest tradition of Military Medical Service."

In a statement from Korea, Major General Edgar Erskine Hume said:

"On the birthday of our Service, I thank the officers and enlisted personnel of all the branches of our complex organization. All have worked hard and in full cooperation. Without the high devotion to duty demonstrated by the officers of the Medical Corps, Nurse Corps, Dental Corps, Veterinary Corps, Women's Medical Specialist Corps, Medical Service Corps and enlisted men as well as attached enlisted women of the Women's Army Corps, we could not have

attained our objective. That objective is keeping the soldier fit to fight and that has been done to the satisfaction of troop commanders of all echelons and to our two medical superiors who have visited us, Surgeons General Bliss and Armstrong.

"Ours has been the duty of caring not only for American soldiers, sailors, marines, and airmen but also for personnel of the other United Nations - Australia, Belgium, Canada, Colombia, Denmark, Ethiopia, France, Great Britain, Greece, India, Luxembourg, Netherlands, New Zealand, Norway, Philippines, South Africa, Sweden, Thailand, and Turkey. Without a thought of rank, race, nationality, or religion of servicemen, you have afforded them professional care of first quality. There is no better place to witness the unity of ideals of all the United Nations than in a military hospital in this command.

"Let us continue our efforts without cease to the end of this conflict."

ARMY SURGEON GENERAL VISITS FAR EAST COMMAND

Major General George E. Armstrong, newly appointed U.S. Army Surgeon General, lost little time in paying a visit to the members of the Army Medical Service in the Far East Command. Less than two months after his appointment to the post, the General arrived in Tokyo to commence a 30-day tour.

The Surgeon General was accompanied by Col. Robert L. Black, MSC; Col. Warner F. Bowers, MC, and Col. John M. Caldwell, MC. Col. Black received notification of his appointment as Chief, Medical Service Corps, during the visit. He will assume his new duties on 24 September, succeeding Colonel Othmar F. Goriup.

The group, accompanied by Major General Edgar Erskine Hume, Chief Surgeon, FEC, left almost immediately for Korea where they toured Army, Corps, Division, Regimental, Battalion and Company medical installations. Upon The Surgeon General's return to Japan, he inspected virtually every major Army medical unit in the nation.

Before General Armstrong departed for the United States, he declared that the medical services in the command are "superb". "I do not see how the medical services -- both in Korea and Japan -- could have done any better than they have," he said.

"We asked the wounded patients specific questions," General Armstrong said, "so that we could get a first-hand picture of medical aid on the battlefront. We asked them their opinion -- and their unit's opinion -- of their medical aid men. Without exception they replied, 'Our medical aid men are great. The only thing wrong is that they take too many chances, they are too courageous.'"

"We also asked them the time element -- how long it took from the time they were wounded until a medical aid man reached them. They showed surprise at this question as nearly all of them said, 'Immediately' or 'From two to five minutes.'"

"One exception to this was the soldier who told me he had to wait an hour and a half for help because 'At the same time I was wounded, our medical aid man was killed.'"

"When we realize," General Armstrong said, "that the outbreak of the Korean conflict found the Medical Corps in the FEC -- along with everyone else -- unprepared, the job accomplished is almost miraculous. The Medical Corps in Japan had less than one half the personnel required for peacetime operations, let alone war, and their accomplishments are magnificent."

GENERAL RIDGWAY COMPLIMENTS NAVY DOCTORS

General Matthew B. Ridgway, in a letter to the Chief, Naval Operations, Washington, D.C., offered his gratitude for services rendered the United Nations effort by the many United States Naval Reserve medical officers who had been attached to Army units in Japan and Korea.

"With the outbreak of hostilities in Korea, in order to relieve the acute shortage of doctors in the Army, the Department of the Navy placed on duty with the Army world-wide, a large number of Naval Medical Reserve officers.

"Now that the acute shortage of Army Medical officers is diminishing, many of the Naval Medical officers

will leave the Army in the Far East Command in May 1951, and proceed to Naval assignments. All others, in accordance with the agreement of the Department of the Army with the Department of the Navy, will proceed to Naval assignments in June 1951.

"After the war began, due to the extreme urgency of the situation, many of the Naval Medical Reserve officers were taken directly from civil life on very short notice and sent directly by air to Army combat units in Korea and to other type Army units in Japan and Korea.

"Through extraordinary adaptation to Army requirements in a combat area, these officers have rendered

invaluable service during a most critical period. In so doing, they have helped the military medical profession lead the way in unification and inter-service cooperation. Their work has been valuable, not only to their own country, but also the United Nations, joined in the common cause of freedom. Their outstanding contribution to the United Nations Medical Service is greatly appreciated."

The letter was forwarded through the Commander, Naval Forces, Far East, Admiral C. T. Joy, who made the following comment:

"Commander Naval Forces, Far East, is highly gratified to note the expressions of the Commander-in-Chief, Far East, which pay such very high tribute to the services rendered by Naval medical officers who have been attached to the Army in Korea.

"It is an exceedingly great pleasure to forward this commendation which is the result of performance considered to have been in full accord with the very

finest traditions of the Naval Service."

In an answering indorsement from the Office of the Chief of Naval Operations, Washington, D.C., to General Ridgway, Admiral L. D. McCormick, Acting Chief of Naval Operations, stated:

"The Chief of Naval Operations is proud of the manner in which personnel of the Naval Medical Corps serving with the U. S. Army have discharged their duties and responsibilities.

"Such outstanding recognition I consider worthy of inviting to the attention of the Secretary of the Navy and you are further assured that when the names of the individual officers concerned are determined a copy of your letter of commendation will be placed in the official record of each.

"It is gratifying also to receive continuing evidence of the increasing efficiency and harmony which accompany unified efforts, exemplified so well by the total composition of your command."

GENERAL HAYS APPOINTED DEPUTY SURGEON GENERAL; GENERAL COONEY FILLS JLCOM POST

Brigadier General Silas B. Hays, Surgeon, Japan Logistical Command, has been appointed Deputy Surgeon General of the United States Army. He proceeded to the United States and his new post late in August.



General Hays' military career began upon his graduation from the University of Iowa in 1928, where he received his medical degree. He went on active duty in June of that year and has served continuously since that date. General Hays is a graduate of the Army Medical School, Medical Field Service School and the Army Industrial College.

During World War II, General Hays served in the

European Command as Chief, Supply Division, OCS-ETOUSA.

He is familiar with the Surgeon General's Office, having served two previous tours there: first for three and a half years prior to his European tour, and again for over five years upon his return. His last duty assignment in the Surgeon General's Office was as Director of Supply.

He was appointed to the rank of Brigadier General on 11 May 1948. Having reported from Hq USARPAC, Hawaii, General Hays was designated Surgeon, Japan Logistical Command on 23 September 1950.

Among the decorations awarded the General are the Distinguished Service Medal, Legion of Merit with Oak Leaf Cluster, Croix de Guerre with Palm and the Ordre de Sante Publique (French).

Brigadier General James P. Cooney, MC, has been appointed Surgeon, Headquarters, Japan Logistical Command, succeeding General Hays.

The new JLCOM Surgeon entered federal service in 1927, after finishing his medical training at the University of Iowa, and has now completed more than 24 years of active duty. He has served at various hospitals in the United States, including Fitzsimons, Letterman, Walter Reed and West Point. He also has served in the Philippines, China and Panama.

During World War II he commanded the 76th General Hospital at Liege, Belgium, and later the 194th General Hospital in Antwerp.

General Cooney is a diplomate of the American Board of Radiology, a member of the American College of Radiology, a member of the Radiological Society of North America, a Fellow of the American College of Chest Physicians, and a member of the National Tuberculosis Association.

He is a graduate of the Army Medical School and Medical Field Service School; he has been awarded the Bronze Star Medal and Commendation Ribbon in addition to various campaign medals.

MEDICAL SUPPLY: LOSSES OF LINEN EXCHANGE ITEMS

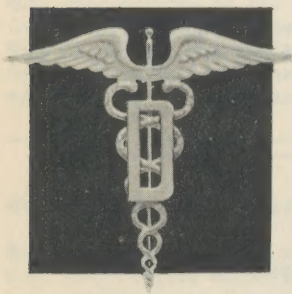
A recent analysis of hospital Reports of Survey, covering losses and/or inventory shortages of linen exchange items, indicates that such losses are extremely high. These losses, though limited to certain specific hospitals, further indicate a general laxity of control measures.

Although patient loads and other conditions during the past year have aggravated normal operational losses, it is pertinent to recognize the necessity

for conservation of all supplies and equipment. Shortages and non-availability of supplies and equipment, more times than not, can be attributed to misuse, unfamiliarity and unintentional negligence on the part of all persons concerned. Certain refinements and developments of hospital control functions should eliminate factors which tend to decrease the effectiveness of hospital management. It is also essential that these refinements and changes be made applicable to supply economy.

MILITARY DENTISTRY AS A CAREER

Major Jack P. Pollock, DC, 3rd Station Hospital, APO 301



With the recent influx of dental officers into the Army as a result of the current mobilization of our Armed Forces, it is considered timely to reiterate some of the advantages of a military career for those in the profession of Dentistry.

Much has been written about the financial security offered by the Army and much has been said about the pension plan. Briefly, to retire with the income offered dental officers with thirty years of service, it would cost approximately \$2,000 annually beginning at age 25 and paid continuously for thirty years. It is also comforting to consider that a steady and periodically increased income will be received monthly, regardless of fluctuating market conditions and without the uncertainty found in civilian practices in critical eras.

The ability to practice one's chosen profession with wholehearted concentration, free of the problems of the business aspect of private practice, is a favorable factor to consider. In a military practice the dental practitioner has at his disposal the finest, most modern equipment and the best available materials. In the ZI he always has well appointed dental clinics in which to practice, and, even in combat zones, every effort is made to provide him with suitable and adequate equipment. At no time does he need concern himself with the rising cost of professional equipment and materials. He can devote himself to the practice of his profession with a mind unencumbered by any thoughts of this nature.

A wealth of patients is available to the military dentist and the experience obtainable is far-reaching in all phases of dentistry. Post-graduate training is available for deserving dental officers of the Army and every effort is made to increase the professional stature of the officers of the Dental Corps. Professionally, the dental officer is limited only by his ability and ambition.

The aforementioned reasons are important, but perhaps another factor is of equal importance from a professional standpoint. That is the medical-dental relationships. It has long been desirable to improve the medical-dental relationships in the

closely allied healing arts of medicine and dentistry. Numerous articles have been written about this, yet there remains considerable effort to be put forth to fulfill the stipulations set down in these writings. All too often dentistry is considered as a purely mechanical profession, but this is only a small part of the science of dentistry. Many systemic diseases originate in the oral cavity or are contributed to by oral foci of infection. In Army practice consultations between dental officers and medical officers are frequent and mutual respect between them is an established condition. With few exceptions, the physicians in Army practice are cognizant of the fact that today's dentists receive a biologic training equivalent to that given a prospective Doctor of Medicine and, as a consequence, the cooperation between the dentist and physician is reflected in the well-being of Army patients. An opportunity is offered the military dentist to increase his scope of experience and knowledge by a harmonious working relationship with the military physician. In the over-all picture, the medical-dental relationships are far more frequent in military practice than in civilian practice and, as a result, the profession of dentistry is enhanced in both the eyes of the medical profession and the average patient.

It is interesting to compare the dental officer of middle age and twenty or thirty years of practice with his civilian counterpart. It is almost without exception that the military dentist has a greater zest for living, an enthusiasm toward the activities of his fellowmen and enjoys a better state of health than the civilian dentist of equal age and experience. Undoubtedly the factors mentioned in the foregoing paragraphs are conducive to a mental composure which contributes to this state of well-being.

In conclusion, it must be pointed out that no one should select military dentistry as a career unless he likes the Army. Never, and this cannot be over-emphasized, should one attempt to combine what amounts to two careers, military and professional, as a line of least resistance. Only by having the desire to be a military professional man and by having high professional ideals will any dental officer contribute to the welfare of the Dental Corps or to himself. Military Dentistry as a career has much to offer those qualified individuals who are willing to uphold the high standards of which the Dental Corps is justifiably proud.

FAR EAST COMMAND MEDICAL SERVICE SPECIALIST SCHOOL
Captain Grayson Smith, MSC, Medical Section, JLCOM



The need for a Medical Service specialist school was realized in January of the current year. At that time plans were being formulated for the establishment of a rotation policy for personnel assigned within Eighth Army. Upon implementation of such a plan the losses thus created would be filled from the replacement pipeline and it was indicated that a large percentage of these replacements coming from the ZI would not have the benefit of specialist training. In order to meet the needs for trained specialists therefore, it was obvious that school facilities would have to be reestablished and operated within Japan Logistical Command. Thus arose the problems of formulating plans which would eventually lead to the establishment of a Medical Service school facility.

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Above: Headquarters building of the Medical Service Specialist School at Shinodayama Barracks, Japan.

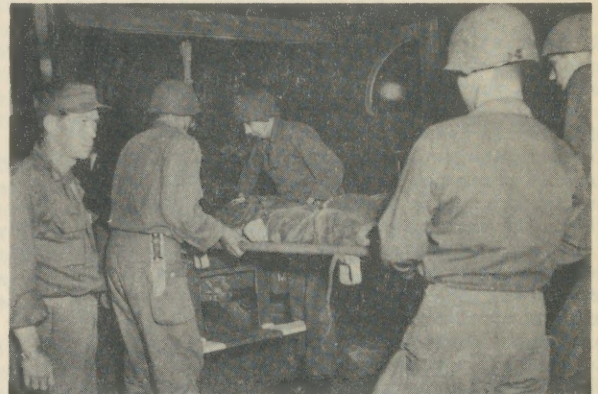
On 10 May 1951, the Commanding General, Japan Logistical Command was directed by CINCPAC to establish a Far East Command Medical Service Specialist School at Osaka, Honshu, Japan, and conduct training in the following courses:

COURSE	MOS	DURATION	FREQUENCY	CLASS CAPACITY	COURSE CAPACITY	PIPELINE QUOTA
I-ray Tech	3264	12 weeks	4 weeks	20	60	15
Pharm Tech	3859	12 weeks	4 weeks	30	90	10
Med Lab Tech	3858	12 weeks	4 weeks	30	90	15
Medical Tech	4123	4 weeks	4 weeks	75	75	30
Op Rm Tech	2861	4 weeks	4 weeks	75	75	30
Med Aid-man	3666	4 weeks	4 weeks	150	150	150
					590	250

The Commanding General, Japan Logistical Command, was authorized to utilize class quotas not assigned to the replacement pipeline as long as quotas utilized did not exceed the overall class capacities shown above.



New students march to theater for orientation course.



Above: Student aidmen practice evacuation problems
Below: Simulated casualty is treated at "Clearing."



ized did not exceed the overall class capacities shown above.



Mr. Levin, Pharmacy Dept, instructs group of students.

In formulating the plans, one of the early considerations was the necessity for obtaining a suitable location where adequate facilities existed for such a school. From 5 July 1946 to the outbreak of hostilities in Korea, a Medical Technicians School was in operation at Osaka Army Hospital. However, the loss of personnel and the need for this facility for hospital beds necessitated its closing on 1 July 1950. An exploration of the possible existing sites revealed the availability of the post at Shinodayama Barracks near Osaka. A thorough survey of this facility was made and it was determined that with a minimum of alteration and repair, it would afford an excellent location for such a school. Shinodayama is located approximately sixteen miles from Osaka, Japan, and in proximity to three general hospitals; the 279th, 382d and Osaka Army Hospital.

Pending approval of the proposed Table of Distribution under which the school is to be organized, a provisional unit was established as of 7 May 1951 by the Japan Logistical Command. As a provisional unit, the Far East Command Medical Service Specialist School is assigned to the Osaka Army Hospital and under the operational control of the Japan Logistical Command. Upon approval of the proposed T/D

the school will be organized as a separate establishment, assigned to the Japan Logistical Command and attached to Southwest Command for certain logistical support.

The school staff was selected from personnel assigned to various medical installations within Japan Logistical Command and medical units of the Eighth Army in Korea. The school Commandant, Lt. Col. Elwood W. Wright, MSC, has had an extensive background in Medical Service training. He served as a Battalion Commander at the Medical Field Service School, Ft. Sam Houston, Texas; as School Commandant of the Medical Technicians School, Osaka Army Hospital, prior to the outbreak of Korean hostilities, and served in Korea with the 1st Cavalry Division and 2d Logistical Command for ten months during the current hostilities.

The Far East Command Medical Service Specialist School began operation on 11 June 1951.

Quotas are allocated based on the following considerations: To pipeline, as directed by CINCPAC to fill needed vacancies in Eighth Army; to FEAF and XVI Corps, as requested and within class capacities; to JICOM units, according to status of training reports submitted showing technicians qualified, not qualified, school trained, not school trained, immediate and future operational requirements.

The Commandant, Far East Command Medical Service Specialist School has authority to award MOS's to students who successfully complete a course of instructions. The provisions of SR 615-25-25, 7 Feb 1951, apply in the awarding of MOS's.

The Medical Service Specialist School is the only unit located on the post of Shinodayama Barracks. It is a beautiful installation conveniently located near the city of Osaka. Recreational facilities on the post are excellent. There is a Service Club, theater, snack bar, library, NCO club, swimming pool, and provisions for sight-seeing trips off the post.

The School may be reached by rail to Osaka, and by bus or local train from Osaka to Shinodayama.

NOTES ON MANAGEMENT IMPROVEMENT

Floyd C. Plowman, Lt. Col., MSC, 3rd Station Hospital, APO 301

Webster defines efficiency as "Effective operation as measured by a comparison of production with cost in energy, time, money, etc". Accordingly, the commander who expends unnecessary personnel, supplies, equipment and funds in completing his mission is not efficient; his victories will be Pyrrhic. The type of commander known as an "empire builder" is a liability to the Army and our country, because any hoarding of means lowers our military potential. The key to victory is only gained through obtaining the maximum results from available personnel, materiel and equipment.

The 1950 Department of Defense manual entitled "The Armed Forces Officer", puts forth this simple and fundamental proposition in saying to the officer corps what may be expected of the average United States soldier under the conditions of battle:

"Extravagance and wastefulness is somewhat rooted in the American character, because of our mode of life. When our men enter military service, there is a strong

holdover of their prodigal civilian habits. Even under fighting conditions, they tend to be wasteful of drinking water, food, munitionment and other vital supply. When such things are too accessible they tend to throw them away, rather than to conserve them in the general interests. This is a distinct weakness during combat, when conservation of all supply is the touchstone of success. The regulating of all supply, and the preventing of waste in any form, is the prime obligation of every officer."

Supply discipline is an inseparable part of efficiency. General Matthew B. Ridgway recently wrote in an official letter on the subject of supply economy:

"Supply economy is the practice of conserving, to the maximum extent practicable, all supplies and equipment in the Armed Forces. It is developed through training and practice until it becomes habit. It includes conservation, maintenance, safeguarding, recovery, repair and salvage of fuel, clothing, food, weapons, transport and all other types of supplies.

The exercise of adequate supply economy is a command responsibility which cannot be delegated. Its effectiveness depends upon the manner in which every individual does his part."

Therefore it behooves all officers to strongly indoctrinate our troops, prior to entering the combat zone, in the principles of total economy: "the battle is the payoff!"

The field of management improvement points out many efficacious ways of assuring continual efficiency in an organization. All units, regardless of size, have three requisites in common: They must be directed, supervised and controlled. In a small unit one man can do all of these. As installations become larger and more complex there tends to be a wide divergence between plans and operations. It then becomes advisable to review operations through a neutral staff element of the organization. American industry has accomplished this by means of a Comptroller who originally exercised control over funds alone, but in the modern concept he constantly reviews and studies all corporate operations. In this way he has become management's primary means of keeping advised on the progress, efficiency, and economy of the corporation's activities. The Comptroller also makes unceasing studies of the effect and impact of changing conditions in order to recommend necessary changes in organization, machinery, methods, etc. The greatness and productivity of American industry, plus its ability to meet the keenest competition, attest to the soundness of this method of guaranteeing efficiency.

In seeking ways to improve its management the Army went to industry. President Truman, then a Senator, through the "Truman Committee" proposed that the very best modern business practices be introduced into the Army. In 1947 the "Haislip Board" recommended that the Deputy Chief of Staff consider creating in his office a management engineering function to keep policies and procedures in the Army under continuous surveillance in order to keep the spotlight constantly on efficiency and economy. The Office of Comptroller of the Army was established by Public Law 216, 81st Congress. Public Law 429 placed the responsibility for overall management for government agencies in the Bureau of the Budget which was required to make an annual report on this subject to the Congress. Management Units were established in FECOM by SCAP and FEC Staff Memo No. 36, dated 24 June 1950.

The best methods of maintaining peak effectiveness at a reasonable cost have ever been the concern of military leaders. General Bradley has said this on the subject:

"National defense has become not only the largest and most important business of the country, but also the costliest. Yet the money which can be made available is limited. When we in the Army are charged with the responsibility of military readiness, we are expected to provide that readiness at a reasonable cost. This requires good management in the Army from top to bottom.

"From the extra shoelaces in a soldier's knapsack to our heaviest tank, supply is a management function as well as a logistical necessity. From the pay of a single private to the total budget for personnel, the pay of the Army requires good management. Training, transportation research, procurement - all require careful management if we are to stay within our budget.

"We in the Department of the Army are trying constantly to perfect our management of the Army as part of the National Military Establishment. We have sought the advice and assistance of able specialists. But our best efforts will be largely wasted unless every man and woman in the Army is likewise working to improve management at his level. It was superb and inspiring teamwork at all levels which brought us success in war. This same teamwork is needed today more than ever if we are to furnish the nation the protection it must have at the price it can pay."

Both the former and present Surgeon Generals of the Army have been vitally interested in this subject: General Bliss started a Management Improvement Program in the Army Medical Service designed to get more and better results from each dollar spent in our fixed hospitals. General George E. Armstrong was highly instrumental in the success of the Program.

It is erroneous to think of this Program merely as reorganization, for it also concerned itself with procedures, administrative methods, equipment and reports to mention only a few of its other fields of interest. As a result our Army hospital administration is rapidly becoming a model of its kind.

The device used by the Surgeon General to assure a continuous study and review of operations in fixed hospitals was the Management Office which was made a part of the organization. The Management Officer's duties are analogous to those of a Comptroller. The management staff carries out its responsibilities solely by analysis, research and recommendation.

It should not be inferred that efficiency is the concern of this specialized staff element only; efficiency is everybody's business. "The Management Unit", a manual published by the Comptroller, GHQ, FEC, asserts:

"Although the Unit (Management) is top managements tool for promoting sounder and more economical administration it has no exclusive right to, or responsibility for, recommending management improvement. This is also a recognized function of the regularly appointed line operating officials of the organization".

There is no best season for efficiency. By making our military personnel efficiency-conscious we can instill in them this trait so vitally necessary in the combat zone where "the battle is the payoff". By increasing the efficiency of our hospitals we can reduce our cost per patient-day and save supplies and equipment easing our transportation and logistical requirements thereby.

All progressive commanders and staff officers are engaged in improving the management of their units or services. One evidence of poor management is personnel waste, caused by such nonproductive personnel practices as "made work", "featherbedding", idleness and overstaffing. In a tour of his organization a commander can - if they exist - note evidences of ineffectives as outlined in the manual entitled "Survey Principles and Techniques" published by the Comptroller, GHQ, FEC:

"People sitting at desks doing personal work * * *;
"Unusual confusion or noise, machines clacking, people shouting to each other above the din, etc.
"Piles of papers on top of workers' desks; piles of papers on top of supervisors' desks but not on workers' desks;
"People walking about a great deal;

"Arguments or discussions going on between workers ***;
 "People reporting for work late or leaving early ***;
 "People getting in each others' way ***;
 "Messengers not knowing where to deliver mail ***;
 "Evidence of outgoing mail not being collected promptly."

SUMMARY:

A workable definition of efficiency is "obtaining the maximum results from the minimum of expenditure of means". In keeping with this definition our highest military and civilian leaders have always been highly interested in reducing waste and extravagance in the Armed Services. The "Truman Committee" proposed that the very best modern business practices be introduced into the Army. Industry had developed the position of the Comptroller to constantly study and review all corporate operations in order to maintain top effectiveness. Comptrollers found it necessary to use sound management engineering principles in effectuating management improvement. The Deputy Chief of Staff upon recommendation of the Haislip Board and in accordance with Public Law 216 established the Office of the Comptroller of the

Army. Management Units were established in FECOM in 1950. The former and present Surgeon Generals have been instrumental in establishing a Management Improvement Program, using the principles developed by Comptrollers, in all fixed hospitals. In this way a large segment of the Army reaffirmed the fact that total efficiency cannot be gained solely by memos, orders and platitudes. The findings of industry were confirmed by the Army: It is necessary in order to assure a continuity of efficiency to have a nonoperating staff element in the organizational structure responsible for constantly analyzing and reviewing operations and recommending needed changes.

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RESERVE MEDICAL OFFICERS ELIGIBLE TO APPLY FOR FELLOWSHIP, A.C.S.

Dr. Howard C. Naffziger, noted brain surgeon of the University of California School of Medicine, has clarified the question of admission of Reserve Officers to Fellowship in the American College of Surgeons. An extract of Dr. Naffziger's letter to The Surgeon General is reproduced as follows:

".....at a recent meeting of the Board of Regents of the American College of Surgeons, I brought up the matter of the admission to Fellowship of Reserve Officers on temporary duty with the Armed Forces. Up to the present those in the Regular Army could apply and were passed upon by a Central Credentials Committee and if accepted, fulfilled the requirements,

they could then become Fellows. There was no similar arrangement for men who were temporarily in the Service and it was necessary for them to put in two years in practice after the military service before they could even come before their local Credentials Committee. The Board of Regents has agreed now that the two year period of service in the Medical Department of the Army and the other branches of Military Service will be accepted in lieu of two years of civilian practice. Applications of these men will be passed on by the Central Credentials Committee in Chicago. This ought to be some additional encouragement to medical officers."

MEDICAL SECTION, GHQ, PREPARING SUPPLEMENTARY ISSUE OF SURGEON'S CIRCULAR LETTER

A supplementary issue of the SURGEON'S CIRCULAR LETTER, "Symposium of Military Medicine in the Far East Command", is on the presses at this time and will be distributed soon.

The symposium is the realization of a long-standing desire on the part of medical officers of the Far East Command to inclose within one cover a compendium of professional thinking on medical matters pertinent to this area.

Forty-two authors are represented in the 144-page publication. Distribution will be made to all medical officers of the Army, Navy, Air Force and United Nations within the Far East. In addition, a representative coverage will be made of medical units in many parts of the world.

Because of the time and printing facilities involved in the preparation of the large supplementary issue, it was found necessary to decrease the size and postpone the publication date of the August issue.

JUTLANDIA DEPARTS FOR INTERNATIONAL VOYAGE

With 205 wounded United Nations servicemen from seven nations aboard, the Danish Hospital Ship, JUTLANDIA, sailed from Yokohama 1 August to begin an international voyage which will end when the last Belgian or Netherlands soldier leaves the vessel in Rotterdam.

terdam.

The patients bound for their homelands include 97 Turks, 40 United Kingdom troops, 49 Greeks, 8 Frenchmen, 6 Belgians, 3 Ethiopians, and 4 members of the Netherlands forces.

The former luxury liner has been scheduled to make stops at Singapore, Aden, Port Said, Smyrna, The Peiraeus, Marseilles and Southampton, arriving at Rot-



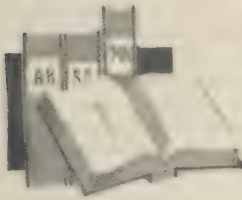
terdam on September 16.

General Matthew B. Ridgway visited the ship immediately before its departure and congratulated Commodore Kai Hammerich, the crew, and shook hands personally with each of the wounded servicemen aboard.

In a brief farewell speech to the assembled guests, Gen. Ridgway lauded the JUTLANDIA for its splendid record of service during its Far East tour and cited the comradeship born on the battlefield by members of the United Nations. The Supreme Commander expressed confidence that this comradeship among the patient passengers would ripen during the voyage.

Major General Edgar Erskine Hume also spoke briefly. He said the contribution of the JUTLANDIA to the medical effort was outstanding and its work in Korea had made many friends for the United Nations in general and Denmark in particular.

RECENT DEPARTMENT OF THE ARMY PUBLICATIONS

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- AR 40-40, 9 Jul 51: Medical Service - Preventive Medicine Officer
 - AR 40-505, 12 Jul 51: Medical Service - Medical Care
 - AR 42-40, C-1; AFR 160-26A, 18 Jul 51: Disease Prevention and Control - Quarantine Regulations for Vessels and Aircraft of Armed Forces
 - AR 345-415, 18 Jul 51: Records - Daily Sick Report
 - AR 35-1120, 19 Jul 51: Finance and Fiscal - Additional Pay for Medical and Dental Officers
 - AR 40-650, AFR 160-98, 27 Jul 51: Medical Service - Central Hospital Fund and Hospital Funds
 - DA CIR 55, 18 Jul 51: Sec II - Physical Examination of Second Lieutenants, Regular Army
 - SR 40-1005-1, 25 Jun 51: Medical Service - Essential Technical Medical Data Report (RCS MED 35(R2))
 - SR 345-415-1, 18 Jul 51: Records - Maintaining the Daily Sick Report
 - SR 41-45-1, C-1, 18 Jul 51: Hygiene and Sanitation-Monthly Sanitary Report (RCS MED-3(R1))
 - SR 600-140-1, 18 Jul 51: Personnel - Line of Duty Determinations
 - SR 40-590-42, C-1, 19 Jul 51: Medical Service - Admission to and Treatment in Medical Facilities, DA, Inside and Outside Continental U. S. of Personnel Entitled to Treatment at the Expense of the U. S. Public Health Service
 - SR 40-590-43, 20 Jul 51: Medical Service - Admission and Treatment of American Seamen in Medical Treatment Facilities of DA Outside Continental U. S., Its Territories and Its Possessions
 - SR 40-1025-50, 24 Jul 51, C-1: Medical Service - Evacuee Report Card (RCS MED-75)
 - SR 40-610-45, 24 Jul 51: Medical Service - Utilization of Personnel at Army Hospitals, Infirmaries, and Dispensaries (RCS MED-87)
 - SR 140-105-6, C-5, 31 Jul 51: Organized Reserve Corps - Appointment in Army Medical Service Sections
 - SR 40-505-11, C-1, 17 Aug 51: Medical Service - Medical Care by Civilian Physicians or Civilian Medical Treatment Facilities
 - SR 40-505-12, 17 Aug 51: Medical Service - Medical Care in Medical Treatment Facilities of Federal Agencies Outside Department of Defense
 - T/O&E 8-520A, 3 Jun 51: Hospital Train (Reorganization to be effected under this table requires specific approval of the Department of the Army.)
 - TC 16, 25 Jun 51: Administrative and Service Teams (T/O&E 8-500-Part I)
 - TC 18, 16 Jul 51: Motor Ambulance and Veterinary Service (T/O&E 8-500-Part III)
 - TC 19, 16 Jul 51: Professional Services (T/O&E 8-500-Part IV)
 - TC 20, 19 Jul 51: Miscellaneous Medical Service Teams (T/O&E 8-500-Part V)
 - TB MED 9, 22 Jun 51: Antibiotic Therapy
 - TB MED 147, 22 Jun 51: Management of Battle Casualties
 - TB MED 172, 22 Jun 51: Treatment of Infectious Diseases with Sulfonamide Drugs
 - TB MED 234, 22 Jun 51: Anesthesia, Resuscitation and Early Care of Wounded, Use of Morphine

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LOEFFLER'S SYNDROME
Captain Lloyd Gregory, MC, Medical Section 4th Field Hospital, APO 301

In 1932 and again in 1936, Loeffler reported on a transitory pulmonary disease characterized by the following triad: (1) mild clinical manifestations; (2) fleeting, migrating, pulmonic infiltrations on x-ray; (3) and blood eosinophilia. By 1940, some 105 cases were described in the literature, consist-

ent with the above syndrome bearing Loeffler's name. Clinically, in one-third of the cases, there are no signs or symptoms, and the condition is found on routine radiography. Symptoms when present include slight fatigue, general malaise, and an irritating cough productive of a slight amount of yellowish, mucoid sputum which is poor in cells, and contains a few eosinophils. Occasionally pain in the chest is present. Temperature may be normal or moderately elevated, and the WBC. may show a mild leucocytosis to as much as 15,000/cu. mm., with an eosinophilia ranging from 6 to 66%. The sedimentation rate may be elevated to 15 mm/hr., corrected.

Loeffler described five types of x-ray shadows:

1. Large, irregular densities which may be fleecy or dense, unilateral or bilateral.
2. Small infraclavicular infiltrations.
3. Circular shadows, single or multiple, unilateral or bilateral.
4. Sharply defined densities situated at the margins of a lobe.
5. Abnormal shadows in the vicinity of the hilum, simulating hilar enlargement. Occasionally there may be pleural effusions. These above transitory shadows appear and disappear in 3 to 8 days. In 5 to 8% of Loeffler's cases, there was a history of asthma. Loeffler did not ascertain the cause of the disease which he discovered in a Swiss tuberculosis sanatorium, but believed that the lung lesion was a specific tissue reaction, probably produced by a variety of antigens and comparable to erythema nodosa of the skin.

It now appears, however, that the syndrome is of greater complexity and variety than originally described by Loeffler. Some other varieties (tropical eosinophilia, eosinophilic pneumonia, allergic pulmonary infiltrations, etc.) have been described by other authors under the same name, and although they differ in some respects from the original description, they appear to be basically the same syndrome.

The author recently reviewed the causes of so-called tropical eosinophilia that may be associated with Loeffler's Syndrome. It can be caused by any of the following parasitic and helminthic diseases: ancylostomiasis, ascariasis, trichinosis, schistosomiasis (japonica), echinococcus, clonorchiasis, amoebiasis, oxyuriasis, paragonimiasis, strongyloidiasis and tapeworm. Because of the high incidence of the above parasites and chronic asthmatic bronchitis in Korea, the author undertook this present study of Loeffler's Syndrome.

PATHOGENESIS:

Wilson and Alexander in their excellent discussions on periarteritis nodosa, suggest that hypersensitive reactions may be of two types, reversible (Loeffler's Syndrome) and non-reversible (periarteritis nodosa). There is a transition from the former to the latter in some instances, and such a transition is similar to the Arthus phenomenon in rabbits which is a local edema or necrosis following subcutaneous injection of the specific antigen in the sensitized animal. Harkavy suggests that any tissue may be involved in the allergic response and that the degree of involvement and the "shock tissue" affected determines the clinical syndrome. While an allergic background suggests a link between the severe and mild cases, such

as Loeffler's Syndrome, views regarding its causative allergens vary.

Engle in Shanghai described cases of "privet cough" occurring in China during the months of May and June, coincident with the flowering of the privet plant. He himself contracted the condition, and x-rays of his chest revealed massive pulmonary consolidations which cleared completely after one day on one occasion, and after 6 days on another. At the same time, his eosinophile count was 20 to 25%, and he ascribed his condition to sensitization to the privet pollen.

Maier described allergic phenomenon in 52 of his 100 cases of Loeffler's Syndrome. These took the form of eczema, hay fever, migraine headache, vascular rhinitis and urticaria. Wright, Gold and Jennings in 268 asthmatic soldiers, picked up pulmonary consolidation on 24 or 9% of their series. They pointed out that atypical virus pneumonia probably existed in approximately one-third of these cases, because of the presence of fever and systemic illness, along with a blood eosinophilia.

Swiss observers have sought to implicate *Ascaris lumbricoides*, having observed migrating pulmonary shadows in association with infestation by this helminth. Perlingier and Gyorgy presented to the literature a 2-year old Negro boy with a case of chronic eosinophilia, anemia and transient pulmonary infiltrations. The patient also had reversible local necrosis of the liver in the presence of ascariasis. The above symptoms and signs all disappeared on hexylresorcinol and methionine therapy.

Wright and Gold report a total of 26 cases of Loeffler's Syndrome out of 76 cases of creeping eruption or cutaneous helminthiasis (*Ancylostoma braziliense*). Hoff and Hicks describe a case in which asthmatic attacks and infiltrations of the lungs disappeared with the discovery and treatment of an amoebic infection. Elsom and Ingelfinger described two cases of extensive, multiple, exudative lesions of the lungs with blood eosinophilia in subjects suffering from infection with *Brucella abortus*. In India, a mite has been isolated from the sputum in some cases, and some authors regard this as an etiological agent, since a cure results from arsenical (carbarsone) therapy.

PATHOLOGY:

Von Meyenberg's report in 1942 in Nazi Germany on 3 soldiers accidentally killed is open to question, because he did not furnish proof of the transient nature of the pulmonary lesions; but he was the first to report on the pathologic anatomy of Loeffler's Syndrome.

The outstanding histologic features of the pulmonary lesions in Loeffler's Syndrome which come to autopsy are the large numbers of eosinophilic leukocytes in the pneumonic exudate. There is also the advanced organization of the exudate with fibrosis and giant cells, the presence of peculiar granulomatous lesions, and the occurrence of necrotizing arteritis and phlebitis, which histologically appears quite similar to the change observed in periarteritis nodosa. According to Baggenstoss, this pathological picture suggests the underlying allergic basis of eosinophilic pneumonia (Loeffler's). Wilson and Alexander in a review of 300 cases from the literature recently found that 18% of patients who had periarteritis nodosa had bronchial asthma. Harkavy was the first to furnish acceptable pathologic data on his four cases of bronchial asthma with Loeffler's Disease that came to post-mortem examination. He

found acute arterial lesions varying from simple thickening of the intima, to acute necrotizing arteritis and endarteritis obliterans.

Experimental injection in animals of foreign protein in the form of specific and non-specific antigens have produced eosinophilia. Herrick in 1913 produced eosinophilia by injection of a suspension of ground ascaris into guinea pigs. Other methods are by sensitization to haptene antigens, such as hydan-toin and sulfonamide drugs. Rich and Gregory at Johns Hopkins drew attention to the fact that "eryth-ema, urticaria, purpura, arthritis, transient paresis, myocarditis, pericarditis, focal swelling and degeneration of collagen, tissue eosinophilia, and necrosis with inflammation of arteries, are common both to rheumatic fever and to anaphylactic reactions of humans with experimental serum sickness". They consider the pulmonary lesions of rheumatic fever and those resulting from anaphylactic hypersensitivity as basically identical. They found that histological lesions occurring in "rheumatic pneumonitis" and pneumonitis resulting from hypersensitivity to sulfonamides to be the same, characterized by capillary damage. They further point out that clinically and experimentally "the sharply focal vascular lesions of periarteritis nodosa can be produced by foreign antigen in the blood stream of the anaphylactically sensitized body."

The expression on the part of the body or a particular tissue in the body to a state of "allergy, hyperergy, or hypersensitivity" may assume many forms. Why there is this variety of response, is not known, and "why eosinophils are not present in all cases of anaphylactic pneumonitis is paralleled by the fact that they are present in some, but not all anaphylactic urticarial lesions". Why this type of eosinophilic pneumonitis does not occur in all cases of acute rheumatic fever remains as obscure as why urticarial or vascular lesions of the periarteritis nodosa type occur in some, but not all cases of rheumatic carditis. Or why hypersensitivity to a given pollen causes asthma in some patients, hay-fever in others, and in some both these conditions. Therefore, the consensus that the eosinophils are produced only by the bone marrow, as first postulated by Ehrlich in 1880, can be superseded by the possibility that they may arise in local tissues as well.

Herbut and Kinsey succeeded in duplicating Loeffler's Syndrome in rabbits, somewhat unlike that seen in man in that there were no blood eosinophilias and the pulmonic shadows were not migratory. Sensitized animals were given single or multiple intratracheal instillations of horse serum. They presented only slight clinical disturbances, such as snorting and sneezing. They presented roentgenographically, transitory pulmonary infiltrations that cleared in 7 to 13 days. There were eosinophils in the tracheal secretions, and pathologically there was congestion, edema, and eosinophilic infiltration of the bronchial mucosa. In the lung parenchyma there was congestion, edema, atelectasis, emphysema, and an eosinophilic pneumonia.

DIFFERENTIAL DIAGNOSIS:

Blood eosinophilia is a feature in the following diseases, and should be ruled out before a diagnosis of Loeffler's Syndrome is tendered:

- 1 - Pruriginous diseases of the skin with repeated excoriations (i.e., dermatitis herpetiformis, lymphoblastomas such as mycosis fungoides, purigo and atopic eczema).

- 2 - Diseases of the skin with excessive destruction of tissue (i.e., pemphigus).
- 3 - Blood Dyscrasias (i.e., Hodgkins Disease, eosinophilic leukemia, myelogenous leukemia and familial eosinophilia).
- 4 - Drug reactions -- including those due to phenyl-ethyl-hydantoin, benzene derivatives and digitalis.
- 5 - Allergic Diseases -- such as urticaria and asthma.
- 6 - Probable allergic diseases -- such as periarteritis nodosa and Loeffler's Syndrome.
- 7 - Miscellaneous diseases and states (i.e., splenomegaly, splenectomy, ingestion of raw liver, intestinal parasites and trichinosis, ultraviolet and x-ray irradiation, chronic brucellosis and tuberculosis). Similar translucent annular shadows of Loeffler's Syndrome are seen on the chest X-ray in the following:

- 1 - Emphysematous pleural blebs or bullae.
- 2 - Bronchiectatic dilatation of the bronchi.
- 3 - Localized pneumothoraces.
- 4 - Pyogenic infection of the lungs.
- 5 - Cystic disease varieties.
- 6 - Virus pneumonia (atypical).
- 7 - Pulmonary Coccidiomycosis.
- 8 - Breakdown of neoplastic tissue in pulmonary tumors.

DISCUSSION:

European writers describe cases of Loeffler-like syndromes which run either a severe, rather septic clinical picture for several months duration; or a clinically mild but chronic course up to seven years. The duration and severity of the migrating, transient lung shadows and blood eosinophilia is unlike the Loeffler Syndrome as originally described.

A review of the recent literature reveals Grace's case which suffered from constant bronchospasm and sporadic asthmatic attacks, with typical pulmonary and other findings of Loeffler's for a protracted course of two years. Elkeles and Butler reported a case of right apical cavitation, associated with eosinophilia, with no evidence of past or present tuberculosis. The patient had a negative O.T. skin test, and repeated sputum tests were negative for acid-fast bacilli. Although the cavity was strongly suggestive of tuberculosis, its rapid and complete disappearance simultaneously with the apical transitory and other pulmonary infiltrations, stimulated the authors to postulate that non-tuberculous pulmonary cavitation may occur in Loeffler's Syndrome. The prominent feature of the six cases of "allergic pulmonary infiltrations" with blood eosinophilia, described by Hansen-Pruss and Goodman, was persistent severe asthma, lack of response to antibiotics and sulfonamides, and a history of frequent upper respiratory infections. In their cases, the asthma persisted until the pulmonary consolidations, which were transient and migratory, cleared.

Harkavy reported eight cases in 1941 and 16 cases in 1943, with recurrent pulmonary infiltrations and eosinophilic polyserositis. All but one of the above cases had asthma and all had sinusitis. Some 70% had positive skin tests to pollens and foods. The WBC. varied from 14,000 to 40,000 and the eosinophilia ranged from 17 to 84%. He considered the condition to be a sensitization or allergy to non-specific

bacteria emanating from chronically infected sinuses, in constitutionally allergic individuals, as well as those who acquire the allergic response.

Coincident with the asthmatic attacks, Harkavy's patients also developed pulmonary infiltrations followed by electrocardiographic changes and sterile pleural effusions, containing up to 100% eosinophils. Pericardial effusion was present in one case, and was succeeded by urticaria and polyarthritides which was not considered of rheumatic origin. Some cases had peritoneal eosinophilic ascites, and one purpuric case on biopsy proved to have eosinophilic granuloma of the skin. These above signs were transient and disappeared on termination of the asthmatic seizures, only to recur with their recrudescence. One case differing from the others only in severity, proved on autopsy to be one of periarteritis nodosa.

Harkavy's cases reported differ from Loeffler's in the more prolonged duration of the pulmonary infiltrations, and the presence of large effusions which had to be aspirated. This suggests that the infiltrations represent hyperergic foci of response in which the interalveolar capillaries, the larger vessels and associated mesenchymal structures participate as "shock" organs; and the edema and cellular filtrate being comparable with the purpura, urticaria, angioneurotic edema, etc., occurring elsewhere in allergy.

At the present time, the exact function of the eosinophile is not known, despite concentrated research the past few years. The work of Selye, Thorne, Hills and others have demonstrated that eosinophile counts before and after stress phenomena or cortisone therapy, are good indications of adrenal cortical function. If would seem, however, that eosinophilia develops as a result of destruction of body tissue, or as a reaction to some protein or haptene antigen. It has been shown that eosinophils are phagocytic for bacteria, trichinella and peptones. In addition, Code has demonstrated that the histamine content of the blood is high in patients with eosinophilia. This raises the question of whether eosinophilia and increased blood histamine are findings produced by a single factor, or whether the eosinophils appear as the result of stimulation by histamine. The suggestion has been made by Kirk, that the eosinophilic granules have a high concentration of histamine, possibly as a protective mechanism.

TREATMENT AND PROGNOSIS:

Since eosinophilic (Loeffler's) pneumonia occurs in the allergic patient and because it can so often be prevented by removal of the offending sensitizing agent, every effort should be directed toward identifying the antigen. After eliminating foci of bacterial infection in the sinuses, naso-pharynx and bronchi by means of anti-bacterial chemo- and immunotherapy, the stool and sputum should be examined for ova and parasites and treated accordingly with specific drugs. If the sensitizing antigen cannot be identified, the prevention of recurrences and symptomatic management with epinephrine, ephedrine, and anti-his-

tamines can be used before secondary invasion of bacteria occurs. Gold reported in early 1950 from Canada, a case of Loeffler's Syndrome treated with adrenocorticotrophic hormone, resulting in a complete remission. Cook claims pyribenzamine and benadryl are of little or no value. Skin and patch tests for offending foods and pollens should be done if attacks of Loeffler's Syndrome, especially with asthma, recur; and a desensitization and elimination program instituted.

Since most cases run a benign course, the prognosis is good. Others are associated with the pathologic changes characteristic of periarteritis nodosa or of disseminated lupus erythematosus, along with a poor prognosis. Almost any tissue may be affected and the condition may be so mild as to pass quite unnoticed, or so severe as to cause the death of the patient.

CONCLUSIONS:

There is thus a variety of clinical manifestations of varying severity and duration, with Loeffler's Syndrome at one end and periarteritis nodosa at the other. There may be transitory pulmonary infiltrations, a blood eosinophilia, and bronchospasm is common. Common to all appears to be a state of hypersensitivity to a variety of agents, and a pathologic reaction including vascular damage, edema, and cellular infiltration. Eosinophils may or may not be prominent in this reaction, and may be found in great numbers in the blood stream or only locally in the tissues affected. This primary reaction in Loeffler's Syndrome appears to be determined by the varying sensitization of blood vessels, and the clinical picture is determined by the character and combination of lung tissues involved.

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IMMUNIZATION AND POLIOMYELITIS

The following statement of policy recommended by the Armed Forces Epidemiological Board and approved by the Surgeon General is furnished for the information and guidance of medical officers who may be called on to render advice on this subject.

"Available evidence indicates that in children who have received immunizing inoculations within a month before development of poliomyelitis, paralysis occurs more frequently in the limbs in which injection had been made than in the corresponding limbs of cases of poliomyelitis with no history of recent injection. The effect of inoculation of other materials, such

as penicillin, novocaine and hormones, has not been analysed completely but preliminary unpublished data suggest that the hazard of developing poliomyelitis is greater among children who have had such inoculations within the previous month. The entire relationship of paralytic poliomyelitis to recent inoculation requires further extensive study before these observations can be accurately evaluated. In any event, the present knowledge is such that until evaluation is forthcoming, elective immunizing inoculations among young children, most of whom are susceptible to poliomyelitis, should be withheld during the summer months. The withholding of necessary inoculations for young children, such as immunizations required for foreign travel or therapeutic inoculations and injections of drugs for treatment of infections,

is not justified on this basis since usually the hazard to life due to disease encountered during foreign travel or due to a current untreated infection is far greater than that from paralytic poliomyelitis which might follow such inoculations.

"In the military population, which is entirely adult and the majority of whom possess poliomyelitis antibodies, the incidence of poliomyelitis is low and it is a relatively unimportant infectious disease of this group. This is in contrast to the important infectious disease in military personnel for which satisfactory immunization procedures are available. Therefore, the withholding of inoculations for immunization and therapy of the military population is not warranted."

THE MANAGEMENT OF PENILE LESIONS IN THE FIELD

Captain Ivan W. Kuhl, MC, 121st Evacuation Hospital, APO 301

The management of penile lesions is one of the vexing problems of a dispensary-type assignment. Treatment and diagnosis of the conditions seen is thoroughly laid out in TB Med 230. However, in the field the tools for making a scientific diagnosis are scarce, if not entirely lacking. This leaves the single tool of clinical experience, which in this field (VD), has been neglected by most medical schools, except for passing mention. This paper has as its purpose aiding those without experience in the field to handle these cases in a satisfactory manner.

The common lesions of the penis in the author's Far East Command experience are as follows:

- | | |
|--------------------------------|--------------------------|
| 1. Chanoroid & Fusospirochetal | 6. Folliculitis |
| Balanitis | 7. Syphilis |
| 2. Scabies | 8. Molluscum Contagiosum |
| 3. Herpes Progenitalis | 9. Granuloma Inguinale |
| 4. Verruca Acuminata | |
| 5. Dermatitis Venenata | |

Of these nine, the first five include over 90% of the penile lesions seen; the last three are very infrequent.

Despite its relative infrequency here, syphilis is the most important and serious disease, and must be ruled out in every suspicious case. Thus our scheme of management must revolve about this consideration.

Important clinical points of recognition by examination in the common conditions follow.

1. Syphilis - The classical primary stage is one or more lesions, which are firm ulcers with clean bases and regular edges that are relatively non-tender. Inguinal adenopathy is present on one side at first and within a few days is bilateral. The buboes are firm and rarely more than slightly tender.

In the secondary stage any of several lesions may be seen. Mascular, papular, condylomata lata, and arciform maculopapular lesions are by far the most common. Usually lesions will be found in other sites at this time; especially on the scrotum, perianal area, palms, soles, and in the oral cavity.

The treatment as noted in TB Med 230, is penicillin in an absorption delaying base, 600,000 Units at 24 hour intervals for 10 injections; given only after positive darkfield or demonstration of rising titer.

2. Chanoroid and Fusospirochetal Balanitis - These

two are lumped because they occur together in practically all cases in which chanoroid involves the area by the prepuce, and the features of both are present.

Chanoroid has as its classical lesions soft, tender, painful, scooped-out ulcers with sharp edges which may be either regular or irregular. The base is usually purulent in appearance. When not under the prepuce, a yellowish-brown crust forms which, on removal, reveals a collection of pus. Buboes form early and become acutely inflamed, exquisitely painful and tender, and frequently form abscesses.

Fusospirochetal balanitis causes shallow ulcerations involving only the topmost layers of the mucosal epithelium and is accompanied by profuse foul-smelling discharge from under the prepuce.

3. Scabies - This is very common and the penis is frequently one of the first noticed sites of infestation. Pruritic papules with scratched tops are suspicious, and because of its frequency, scabies treatment should be given in all such cases.

4. Herpes progenitalis - This is simply herpes simplex on the penis. The cluster of vesicles may have lost their tops and be shallow punched out ulcers when first examined. This condition heals spontaneously in 7 to 14 days.

5. Verruca Acuminata - These are conical papules of flesh readily recognized. The lesions usually respond to podophyllin locally. Caution must be taken to cleanse the penis thoroughly within two hours after application to avoid the occurrence of chemical balanitis.

6. Dermatitis Venenata - Acute dermatitis venenata due to plants is quite common on the penis since the allergen is transferred to the penis when the man urinates. Occasionally a dermatitis venenata of the penis is caused by medication applied to the groin for tinea cruris. The essential lesion of dermatitis venenata is an acute erythematous edema, usually to the point of vesiculation, confluent in the area of exposure to the allergen. This is usually seen in other sites concurrently, especially on face, arms, legs, and the backs of the hands.

7. Folliculitis - Inflammation about the hair follicles is quite common in Korea because of poor hygienic conditions. This clears in 3 to 5 days with the use of soap and water. Occasionally shallow ulcerations form which will respond to soap

and water plus sulfadiazine.

8. Molluscum Contagiosum - This condition consists of slightly pruritic umbilicated grayish rose-colored papules. Curettage of the lesions followed by the application of a local antiseptic to the bases is curative.

9. Granuloma Inguinale - The most frequent site of onset of this disease, seen almost exclusively in negroes, is the penis. The lesion is a soft, elevated, succulent papule or nodule with a velvety easy bleeding surface. The treatment consists of streptomycin 1 gram 4 times daily, for 5 days and should be administered only after the identification of Donovan Bodies by individuals experienced in their recognition. If this condition is suspected the man should be sent to the larger medical facilities where experienced technicians and personnel are available.

The common lesions of the penis may be divided into those which itch, and those which do not, or do so only rarely.

	PRURITIC	NON-PRURITIC
Decending order	Scabies	Chancroid & Fusospirochetal Balanitis
	Dermatitis Venenata	Verruca Acuminata
Pruritus	Folliculitis	Syphilis
	Molluscum Contagiosum	Granuloma Inguinale
	Herpes Progenitalis	

Divided in this manner, diagnosis is greatly simplified and coupled with other characteristics mentioned above, diagnosis is usually readily made. Unfortunately, herpes progenitalis does not always itch and burn noticeably, so it may be easily confused with chanoroid.

In the management of cryptogenic penile ulcers, it is suggested that sulfadiazine 1 gram 4 times daily (OP basis) or sulfadiazine 1 gram every 4 hours, with plenty of fluids, be given. If balanitis is present KMnO₄ soaks 4 times daily is recommended. Herpes and chanoroid take a minimum of 3 days to show appreciable response to sulfadiazine every 4 hours, and from 4 to 5 days when taken 4 times daily.

Darkfield examination should be instituted as early as possible if readily available. If the cryptogenic ulcers do not respond in 5 to 6 days, the man should

be sent to a facility where darkfield examination is available. If darkfield examination is negative over 3 days period, streptomycin will exert a favorable influence on the course of chanoroid.

If buboes break down to form abscesses, repeated aspiration should be done. Serologic follow-up should be instituted in all cases in which the diagnosis is uncertain. TB Med 230 recommends that a serology be taken weekly for the first month, and monthly for the next 3 months to rule out syphilis.

It should be noted that penicillin and aureomycin are not used and streptomycin is used only after the darkfield examination is repeatedly negative. Penicillin and aureomycin are treponemicidal, and as such prevent the diagnosis of syphilis from being made or eliminated by the best means (darkfield demonstration of T. Pallidum). Only if the man is allergic to sulfadiazine, may aureomycin be used.

Sulfadiazine is the drug of choice for the cryptogenic ulcer of the penis since it (a) is a sulfa drug of low toxicity, (b) is curative in chanoroid and lymphopathia venereum (lymphogranuloma venereum) (c) exerts a favorable effect on fusospirochetal balanitis; augmented with KMnO₄ soaks is curative, (d) has no effect on T. Pallidum (e) exerts a favorable effect on secondary infection in syphilitic ulcers (making demonstration of T. Pallidum less difficult) and herpes progenitalis (f) keeps the "miracle drugs", penicillin, streptomycin, and aureomycin from sensitizing the man, so they may be used later for a more desperate condition if need be. (g) prevents the development of resistant strains of organisms to penicillin, aureomycin and streptomycin, (h) is readily available in quantity. The dangers of using the sulfa drugs are well known and should be considered in treatment.

SUMMARY:

1. Common causes of penile lesions have been listed, stressing their clinical features rather than laboratory diagnosis.
2. Methods of management of such lesions at forward field medical stations have been suggested.
3. The importance of restraint in the use of specifics prior to adequate diagnosis has been emphasized.

IMPROVED PUMP FOR RAPID INTRAVENOUS AND ARTERIAL TRANSFUSIONS

Capt William M. Chardack, MC - Capt Charles R. Reiners, Jr., MC, 8029th Mobile Army Surgical Hospital

The need and importance of rapid restoration of blood volume in the severely wounded and injured requires no emphasis. Acceleration of the rate of transfusion is usually accomplished by manual stripping of the tubing or the use of a bulb to build up pressure in the blood bottle. The latter system often results in the disruption of the donor set due to excessive pressure and also carries the risk of inadvertent injection of air into the patient. Various other devices described in medical literature are too cumbersome and complicated for use under field conditions.

The device described herein has been used in former times for indirect transfusions and more recently for experimental perfusion problems. It can be easily built up by any mobile machine shop and as a matter of fact the rotor base was constructed of a cut down 105 mm artillery shell. This apparatus has been used

with gratifying results in a number of cases suffering from severe shock in the 8209th MASH.

The main features of the pump are:

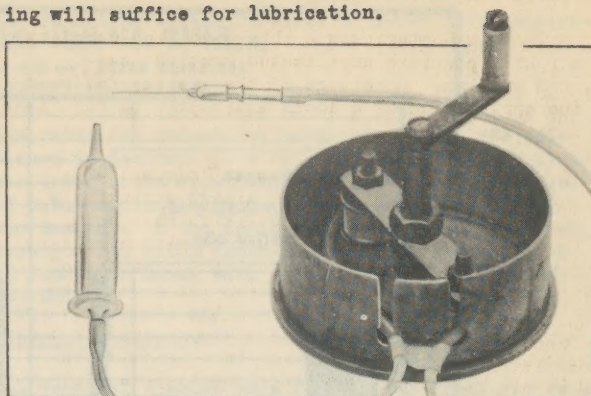
1. Simple and foolproof operation. No pressure can build up proximal to the outgoing loop of the tubing. It is bubbleproof and no air under pressure is in contact with the blood.
2. It requires no sterilization and can be used with the standard expendable tubing or disposable blood recipient sets.
3. Outflow and pressure are determined and controlled by the speed of rotation of the handle. At 60 rpm, 100 cc of blood requires 60 seconds to pass through an 18 gauge needle. At 130 rpm, 100 cc of

blood passes through the apparatus every 35 seconds.

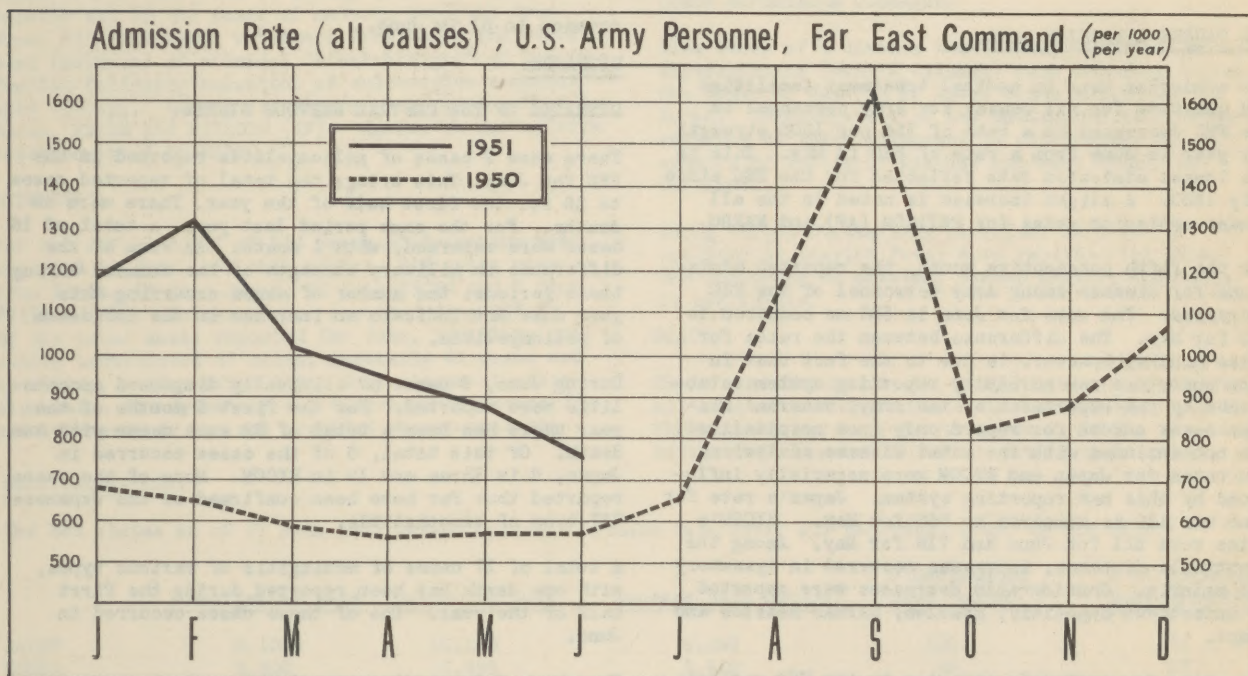
4. Possible hemolysis is an objectionable feature that became known when this type of pump was used for artificial heart experiments in which the same blood was pumped through over and over again. We have tested the blood for an increase in hemolysis after letting it go through the pump once and have found it to be so minimal that it is hardly discernable to the naked eye and of no practical significance.

5. Operation is exceedingly simple. The loop of tubing inside the pump should be adjusted in order to fit snugly around the rotors. This position can be maintained by a piece of adhesive tape just outside of the slots, as shown in the diagram. This will prevent feeding of the tubing into the pump as the rotors turned. A few drops of mineral oil on the tub-

ing will suffice for lubrication.



HEALTH OF ARMY TROOPS, FEC



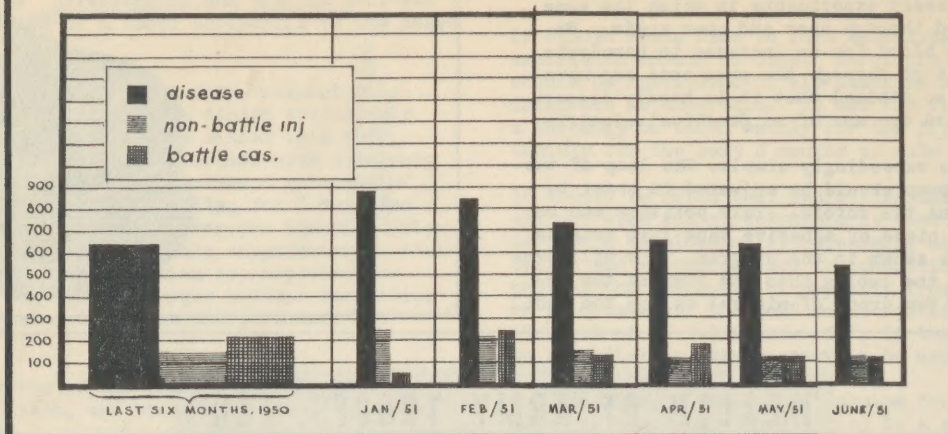
Admission rates per 1,000 troops per annum, Army personnel, for the 4-week period ending 27 June 1951 were as follows:

	FEC	JAPAN	KOREA	MARBO	PHILCOM(AF)	RYCOM
All Causes	755	498	895	366	373	565
Diseases	532	430	536	259	302	521
Injuries	112	68	137	107	70	45
Battle Casualties	111	0	172	0	0	0
Psychiatric	44	24	56	5.6	0	12
Common Respiratory Diseases and Flu	67	67	67	62	50	52
Primary Atypical Pneumonia	2.6	2.7	2.7	0	0	0
Bacillary Dysentery	2.5	.37	3.2	0	0	9.5
Amebiasis	1.5	.73	1.8	0	20	2.1
Malaria, new	25	42	18	0	40	13
Infectious Hepatitis	9.9	5.8	12	0	0	14
Dermatophytosis	5.8	4.5	6.0	5.6	0	15
Rheumatic Fever	.83	1.1	.70	0	0	1.1
Veneral Diseases	150	148	150	23	30	211

DAILY NON-EFFECTIVE RATES

	FEC	JAPAN	KOREA	MARBO	PHILCOM(AF)	RYCOM
All Causes	34	81	13	11	56	15

DISEASE, NON-BATTLE INJURY AND BATTLE CASUALTY
ADMISSION RATES (per 1000 per year) U.S. ARMY PERSONNEL, FEC



ALL CAUSES ADMISSION RATE:

The admission rate to medical treatment facilities and quarters for all causes for Army personnel in the FEC decreased to a rate of 755 per 1000 strength per year in June from a rate of 880 in May. This is the lowest admission rate reflected for the FEC since July 1950. A slight increase is noted in the all causes admission rates for PHILCOM (AF) and MARBO.

For the fifth consecutive month, the reported admissions for disease among Army personnel of the FEC decreased. The rate for June is 532 as compared to 638 for May. The difference between the rates for these months, however, is due to the fact that in June under the new morbidity reporting system established by the Department of the Army, venereal disease cases carded for record only (not hospitalized) are not included with the total disease admissions. The rates for Japan and RYCOM were especially influenced by this new reporting system. Japan's rate for June was 430 as compared to 588 for May. RYCOM's rates were 521 for June and 716 for May. Among the reportable diseases, increases occurred in dysentery and malaria. Considerable decreases were reported in infectious hepatitis, measles, German measles and mumps.

The rates for nonbattle injuries in the FEC reflects a slight decrease from 121 in May to 112 in June. This decrease is the result of a lessened rate in Korea from 154 in May to 137 in June, and for RYCOM from 70 in May to 35 in June. Other commands reported slight increases.

The battle casualty admission rate for the FEC decreased slightly from the previous month from 121 for May to 111 for June. This is the lowest battle casualty rate reported since January when the rate was 52. The June battle casualty rate reported for Korea is 172. The rate reported for January was 76.

DAILY NON-EFFECTIVE RATE:

The daily non-effective rate for the FEC continued the downward trend, and was 34 in June as compared to 35 last month. This is the lowest rate since July 1950. The rates for Korea and RYCOM were the same as the previous month, while MARBO and PHILCOM (AF) had small increases. Japan's rate in May was 87 and de-

creased to 81 in June.

DISEASES:

DISEASES OF THE CENTRAL NERVOUS SYSTEM:

There were 9 cases of poliomyelitis reported in the FEC for June. This brings the total of reported cases to 25 for the first half of the year. There were no deaths. For the same period last year, a total of 16 cases were reported, with 1 death. In view of the difference in military strength of the command during these periods, the number of cases occurring this year does not indicate an increase in the incidence of poliomyelitis.

During June, 6 cases of clinically diagnosed encephalitis were reported. For the first 6 months of the year there has been a total of 29 such cases with one death. Of this total, 5 of the cases occurred in Japan, 9 in Korea and 15 in RYCOM. None of the cases reported thus far have been confirmed as the Japanese "B" type of encephalitis.

A total of 17 cases of meningitis of various types, with one death has been reported during the first half of the year. One of these cases occurred in June.

The above data on diseases of the central nervous system include not only those cases occurring among U. S. military personnel, civilian employees and dependents, but also one case of encephalitis from French military personnel in Korea, one case of encephalitis and one case of poliomyelitis in missionary dependents and two cases of poliomyelitis occurring in dependents of an American consular official.

PSYCHIATRIC:

The incidence of psychiatric conditions increased in the FEC from a rate of 24 for May to a new rate of 44 for June. Both Japan and Korea contributed to this increase, Japan with a June rate of 24 as compared to the 9.9 rate for May, and Korea with a rate of 56 for June as compared with a rate of 31 for May. The rate for RYCOM remained the same, MARBO reported a lower rate, and again PHILCOM (AF) reported no cases. This high incidence rate occurred despite a drop in both battle casualty and disease rates. It is difficult to explain this rise of incidence on the basis of in-

creased stress, particularly since rotation was operating effectively during June. A known cause for the increased rate is the re-hospitalization of hospital returnees who were sent to their original combat organizations for non-combat assignments. The number of non-combat assignments in combat organizations and divisions is too few to absorb all personnel of re-profiled category, therefore such individuals were again evacuated through medical channels. Since then, the policy of the assignment of reprofiled returnees to combat units has been discontinued. The psychiatric rate for the next month should reflect a more realistic picture of the incidence of psychiatric casualties. Another possible reason for this increase may be the reflection of a more accurate picture of psychiatric conditions because of the new reporting system initiated in June.

MALARIA:

The incidence rate of new malaria continued to rise in June for the FEC from the May rate of 15 to a rate of 25 for June. The sharpest increase occurred in Japan with a rise from 19 in May to 42 in June. Practically all of the cases of malaria reported from Japan occurred among returnees from Korea and represent incidence of clinical "breakthroughs" of the infection following cessation of chloroquine suppressive therapy. Only a slight increase was reported in Korea, RYCOM and PHILCOM (AF). Again, no new malaria cases occurred in MARBO.

DYSENTERY:

For the FEC, a total of 249 cases of dysentery was reported in June. Of this number, 218 cases came from Korea, 16 from Japan, 13 from RYCOM and 2 from PHILCOM (AF). No cases were reported from MARBO. Of the total cases reported for June, bacillary dysentery contributed 67 cases, amebiasis 41 cases and dysentery, unclassified 141. Comparisons of admission rates for dysentery and diarrheal disorders for previous periods are not provided since under the

HOSPITALIZATION:

The bed status as of 27 June 1951 was as follows: (These data cover all patients, Army, AF and others.)

	<u>Designated Beds</u>	<u>Operating Beds</u>	<u>Average Beds Occupd.</u>	<u>% Designated Beds Occupd.</u>	<u>% of Operating Beds Occupied</u>
JAPAN	8,100*	10,100	9,195	114	91
KOREA	3,900	2,998	2,410	62	80
MARBO	200	200	57	29	29
PHILCOM (AF)	200	116	74	37	64
RYCOM	400	384	293	73	76
FEC	12,800	13,798	12,029	94	87

(* Does not include 2,000 TD beds.)

EVACUATION:

Tabulated below is the number of patients (all types of personnel) evacuated from the major commands to the ZI during the four report weeks in June and the number of patients awaiting evacuation as of 29 June 1951:

	<u>JAPAN</u>	<u>MARBO</u>	<u>PHILCOM (AF)</u>	<u>RYCOM</u>	<u>FEC</u>
By Air	2,627	2	40	71	2,740
By Water	7	0	1	9	17
Total	2,634*	2	41	80	2,757
Patients Awaiting Evacuation	118	3	1	42	164

(* 2,181 patients originated from Korea.)

new reporting system referred to above such comparisons would not be valid.

INFECTIOUS HEPATITIS:

The rates for infectious hepatitis in the FEC continued to decrease to a rate of 9.9 in June. This is the lowest rate experienced since the December rate of 9.8. Again the lower rate is primarily due to the decrease in the incidence of hepatitis in Korea. The rate for RYCOM increased from 6.9 in May to 14 in June. No cases were reported from PHILCOM (AF) and MARBO.

VENEREAL DISEASES:

The venereal disease rate for the FEC increased from 131 in May to 150 in June. This increase reflects the increased rate for Korea from 122 in May to 150 in June. The rates for Japan, PHILCOM (AF) and RYCOM remained static. Slight increases were reported in MARBO.

OTHER REPORTABLE DISEASES:

Nine cases of a disease tentatively diagnosed as leptospirosis (Weil's disease) were reported during the month of June, 8 of these cases originated in Korea. Investigation of the nature and mode of occurrence of these illnesses is continuing. The diagnosis of leptospirosis has not been firmly established.

Among United States Army personnel no cases of smallpox or scarlet fever were reported for June. The incidence of measles, German measles and mumps is negligible.

DEATHS:

There were 105 deaths due to all causes reported by all medical treatment facilities in the FEC in June. Thirteen deaths were due to disease, 23 due to non-battle injuries and 69 due to battle casualties.

RESTRICTED



The Chief Surgeon extends an invitation to all Far East Command medical personnel of the U. S. Army, Navy and Air Force, or of the United Nations, to prepare and forward with view to publication, articles of professional or administrative nature. It is assumed that editorial privilege is granted unless author states otherwise.

Lt. John J. Griffin, Editor

RESTRICTED